DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	144040	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO BEHAVIORAL HOSPITAL	555 WILSON LANE DES PLAINES, IL 60016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

A 000 INITIAL COMMENTS

An Investigation was conducted 06/08/17 for Complaint # IL00093947/172433 and IL00093757/172418. The Hospital was not in compliance with the Condition of Participation of 42 CFR 482.13, Patient Rights for Hospitals as evidenced by:

A 115 482.13 PATIENT RIGHTS

A hospital must protect and promote each patient's rights.

This CONDITION is not met as evidenced by: Based on document review, observation and interview, it was determined for 7 of 7 inpatient psychiatric units (Adolescent, General Adult, Dual Diagnosis, Women's Program, Transitional Care, Intensive Treatment, and Geriatric Units) and 6 of 10 (Pts #1, 2, 3, 4, 5, and 7) clinical records reviewed, that the Hospital failed to ensure patients' rights were protected. As a result, the Condition of Participation for Patient Rights, 42 CFR 482.13, was not met.

Findings include:

1. The Hospital failed to ensure safety unit checks were conducted, as required. See deficiency at A-144A.

2. The Hospital failed to ensure a plastic bag was not in a patient bathroom. See deficiency at A-144B.

3. The Hospital failed to ensure safety precautions were conducted every 15 minutes, as required by policy. See deficiency at A-144C.

A 000
Without confirming or denying the truth, accuracy and completeness of the items set forth in the Statement of Deficiencies, the provider submits the following Plan of Correction. The Statement of Deficiencies was received by the provider on 6/23/2017. Therefore, this Plan of Correction is being submitted timely."

A 115 A 115 7/1/2017

The hospital protected and promoted patient's rights and safety by:
[A 144 (A)] The policy entitled "Safety Checks Unit" was amended to reflect the Safety Officer providing oversight for the process and completion of Safety Unit Checks. A new procedure for collection and verification of completion of safety unit checks was created. Safety Officer or Designee completes Safety Unit Checks daily in all active patient care areas. Results were reviewed, and problems identified were corrected. Mental Health Technicians and RN Staff were re-educated by June 22, 2017 about performing evaluations for unit safety on an ongoing basis, and to address safety issues in real time, notifying appropriate parties, and taking immediate action. Safety Officer collects all Safety Unit Checks completed by the Safety Officer or Designee, and audited for completion. Any deficiencies are reported to administration, and monthly compliance is reported to the Safety Committee and Performance Improvement Committee. This will be monitored for four consecutive months with a measurement of success goal of 100% compliance. The person ultimately responsible for this action is the Safety Officer.
[A 144 (B)] The Deficiency noted in A 144 (B) was discovered during an observational tour of the Adolescent Unit, which was vacant of all patients and under planned maintenance. The plastic bag was found in an open patient bathroom trash bin within a few feet of a painting contractor. It was confirmed to the surveyor by the contractor, that the plastic bag had been recently placed there by the contractor. When units undergo maintenance, the Safety Officer or Designee evaluate the patient care area for compliance with safety requirments prior to patients returning to the milieu. All plastic waste bags were removed from patient care areas, including RN Stations, and covered receptacles. Paper Bags are used instead. Items delivered in plastic bag packaging, were removed from the plastic bag and placed in covered or sealed containers in locked rooms. Policy entitled "Contraband" was amended to include plastic bags as a contraband item, except in the case of brief use for trash collection, in which staff will maintain control of the bag, and bio-hazard bags which are kept in a container in the locked medi[illegible]oom. Weekly Infection Control, Safety, and Risk Rounds performed by the Infection Control RN, Safety Officer, an[illegible]irector of Risk Management, will monitor for continued compliance. All issues will be reported to the Safety Officer for immediate resolution. The person ultimately responsible for this action is the Safety Officer.
[A 144(C)] All RN Staff were re-educated by June 22, 2017 to provide oversight for completion of 15 minute rounds sheets. 15 minute check documentation was revised, adding a field for documenting that RN Staff will perform at minimum one 15 minute checks per shift. As well, RN Staff will review documentation for completion, and confirm the completion of the form each shift. Audits will be performed on 50 medical records monthly to ensure full and accurate completion of 15 minute rounds sheets. The results will be reported to the Performance Improvement Committee. This will be monitored for four consecutive months with a measurement of success goal of 100% compliance. Administration will do periodic random compliance reviews to ensure compliance with patient rounding. These reviews will occur weekly on all active patient care areas for four consecutive months. The person ultimately responsible for this action is the Chief Nursing Officer.
[A 168 (A)] Restraint and Seclusion Order Form was revised, approved, and re-educated to all RN staff by June 22, 2017. Physicians were informed about changes in documentation. The updated Order Form required that each separate intervention,
even if part of one event, required its own order form. All RN staff were educated on the hospital policy defining seclusion as "Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior", from policy "Restraint and/or Seclusion". Hospital Leadership developed a post-event review process to evaluate all uses of restraint and seclusion. This review process includes documentation evaluation, chart review, and staff education when needed. Results of the reviews are presented to the Performance Improvement Committee. The person ultimately responsible for the action is the Chief Nursing Officer.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Anthony DeJoseph | CEO | 6-30-2017 / 06/08/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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4. Tthe Hospital failed to ensure a physician's order was written for a patient placed in restraint/seclusion. See deficiency at A-168.

5. The Hospital failed to ensure restraints were not ordered as a PRN (as needed). See deficiency at A-169.

6. The Hospital failed to ensure patients were not restrained longer than allowed. see deficiency at A-171.

A 144 482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING

The patient has the right to receive care in a safe setting.

This STANDARD is not met as evidenced by:
A. Based on document review and interview, it was determined that for 7 of 7 patient care units in the Hospital (Adolescent, General Adult, Dual Diagnosis, Women's Program, Transitional Care, Intensive Treatment, and Geriatric Units), the Hospital failed to ensure safety unit checks were conducted, as required. This could potentially affect the safety and well being of the average daily census of 128 patients in the Hospital.

Findings include:

1. The Hospital policy entitled, "Safety Unit Checks," (Revised 11/14) reviewed on 6/7/17 at approximately 8:00 AM required, "I. Purpose: To provide and maintain a safe physical environment for patients ...on the unit. II. Policy: A. Each day the charge nurse/designee shall make unit rounds, including a visual scan of each patient's room, to check for unauthorized items ...and

[A 169] Restraint and Seclusion Order Form was revised, approved, and re-educated to all RN staff by June 22, 2017. Physicians were informed about changes in documentation. The updated Order Form required that each separate intervention, even if part of one event, required its own order form. The wording on the document was revised to remove the statement "If needed for emergency management, restraint/seclude for...". Re-education was provided to all RN staff by June 22, 2017 on the hospital policy prohibiting the use of Restraint/Seclusion orders as PRN, from policy "Restraint and/or Seclusion". Hospital Leadership developed a post-event review process to evaluate all uses of restraint and seclusion. This review process includes documentation evaluation, chart review, and staff education when needed. Results of the reviews are presented to the Performance Improvement Committee. The person ultimately responsible for the action is the Chief Nursing Officer.
[A 171] Restraint and Seclusion Order Form was revised, approved, and re-educated to all RN staff by June 22, 2017. Physicians were informed about changes in documentation. The updated Order Form required that each separate intervention, even if part of one event, required its own order form. The order form states the maximum time interventions can be applied, per state law, based off of age of the patient. RN Supervisors were re-educated by June 30, 2017 to provide oversight to ensure that times are accurately documented, and that interventions do not exceed maximum times per state law. Hospital Leadership developed a post-event review process to evaluate all uses of restraint and seclusion. This review process includes documentation evaluation, chart review, and staff education when needed. Results of the reviews are presented to the Performance Improvement Committee. The person ultimately responsible for the action is the Chief Nursing Officer.
[A 395] Policy entitled "Physician Orders" was amended to reflect that medication orders are hand delivered or faxed to the pharmacy. RN Staff was re-educated by June 22, 2017 by the Chief Nursing officer, to clarify the policy. The person ultimately responsible for this action is the Director of Pharmacy. The Director of Pharmacy/Designee is available 24 hours daily, to ensure that all medications ordered have been dispensed per physician's order, in a timely manner. Pharmacy Director/Designee ensures that medications are stocked and available during off hours, per policy. Ongoing compliance is being monitored via weekly pharmacy, storage, and medication room inspections. Ongoing audits are completed to ensure all medications ordered were received by the pharmacy within four hours of transcription. RN Staff were re-educated by June 22, 2017 about the process for obtaining medications on off hours. This includes use of the night cabinet, obtaining medications from a local pharmacy, or contacting the Director of Pharmacy/Designee for guidance. This audit will be reported to the Pharmaceuticals and Therapeutics Committee, and the Performance Improvement Committee. The person ultimately responsible for this action is the Director of Pharmacy.

A 144 (A) 6/26/2017

The policy entitled "Safety Checks Unit" was amended to reflect the Safety Officer providing oversight for the process and completion of Safety Unit Checks. A new procedure for collection and verification of completion of safety unit checks was created.
Safety Officer or Designee complets Safety Unit Checks daily in all active patient care areas. Results were reviewed, and problems identified were corrected. Mental Health Technicians and RN Staff were re-educated by June 22, 2017 about performing evaluations for unit safety on an ongoing basis, and to address safety issues in real time, notifying appropriate parties, and taking immediate action. Safety Officer collects all Safety Unit Checks completed by the Safety Officer or Designee, and audited for completion. Any deficiencies are reported to administration, and monthly compliance is reported to the Safety Committee and Performance Improvement Committee. This will be monitored for four consecutive months with a measurement of success goal of 100% compliance. The person ultimately responsible for this action is the Safety Officer.

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property damage ...III. Procedures ...6. In the event of an injury to a patient ...completes an incident report that ensures that appropriate steps, including follow-up have been implemented."

2. The Adolescent Unit Safety Check Sheets for the months of April 2017, May 2017, and June 2017 were reviewed on 6/7/17 at approximately 8:00 AM. The documentation of daily checks was not found as required on: 4/1/17; 4/3/17; 4/8/17; 4/10/17; 4/13/17; 4/15/17; 4/17/17; 4/23/17; 4/25/17; 4/29/17; 4/30/17; 5/1/17; 5/2/17; 5/8/17; 5/12/17; 5/13/17; 5/14/17; 5/15/17; 5/19/17 through 5/22/17; 5/2617; 5/27/17; 5/28/17; 5/30/17; and 5/31/17; 6/1/17; 6/3/2017; and 6/6/17.

3. The General Adult Unit Safety Check Sheets for May and June 2017 were reviewed on 6/7/17 at approximately 8:45 AM. The documentation of daily checks was not found as required on May 1-22, 2017 and May 24-30, 2017.

4. The Dual Diagnosis Unit Safety Check Sheets for May and June 2017 were reviewed on 6/7/17 at approximately 9:00 AM. The documentation of daily checks was not found as required on May 1-23, 2017 and June 1-6, 2017.

5. The Women's Program Unit Safety Check Sheets for May and June 2017 were reviewed on 6/7/17 at approximately 9:10 AM. The documentation of daily checks was not found as required on May 1-20, 2017.

6. The Transitional Care Unit Safety Check Sheets for May and June 2017 were reviewed on 6/7/17 at approximately 9:15 AM. The

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documentation of daily checks was not found as required on: May 15-24, 2017; May 26-28, 2017; and May 30, 2017.

7. The Intensive Treatment Unit Safety Check Sheets for May and June 2017 were reviewed on 6/7/17 at approximately 9:20 AM. The documentation of daily checks was not found as required on: May 1-21, 2017; May 26-28, 2017; May 30, 2017; May 31, 2017; and June 1-4, 2017.

8. The Geriatric Unit Safety Check Sheets for May and June 2017 were reviewed on 6/7/17 at approximately 9:20 AM. The documentation of daily checks was not found as required on May 1-26, 2017; May 27, 2017; and May 31, 2017.

9. The Director of Performance Improvement and Risk Management (E #3) stated, during an interview on 6/7/17 at approximately 2:20 PM, that the Unit Safety Checks should be done every shift; however, the policy requires daily unit safety checks.

B. Based on document review, observational tour, and interview, it was determined, for 1 of 3 patient bathrooms, the Hospital failed to ensure that a plastic bag was not in a patient bathroom, potentially injurious to 4 adolescent patients (Pts. #7 - 10) on suicidal precautions.

Findings include:

1. On 6/7/17 at 11:30 AM, the Hospital policy titled, "Contraband", effective 11/2014, was reviewed. The policy did not include plastic bags as contraband.

2. On 6/7/17, between 8:55 AM and 10:30 AM,

A 144 (B) 6/23/2017

The Deficiency noted in A 144 (B) was discovered during an observational tour of the Adolescent Unit, which was vacant of all patients and under planned maintenance. The plastic bag was found in an open patient bathroom trash bin within a few feet of a painting contractor. It was confirmed to the surveyor by the contractor, that the plastic bag had been recently placed there by the contractor. When units undergo maintenance, the Safety Officer or Designee evaluate the patient care area for compliance with safety requirements prior to patients returning to the milieu. All plastic waste bags were removed from patient care areas, including RN Stations, and covered receptacles. Paper Bags are used instead. Items delivered in plastic bag packaging, were removed from the plastic bag and placed in covered or sealed containers in locked rooms. Policy entitled "Contraband" was amended to include plastic bags as a contraband item, except in the case of brief use for trash collection, in which staff will maintain control of the bag, and bio-hazard bags which are kept in a container in the locked medication room.
Weekly Infection Control, Safety, and Risk Rounds performed by the Infection Control RN, Safety Officer, and the Director of Risk Management, will monitor for continued compliance. All issues will be reported to the Safety Officer for immediate resolution. The person ultimately responsible for this action is the Safety Officer.

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an observational tour was conducted in the adolescent unit. A plastic bag was in a waste container in a patient bathroom (no number on the room) across from the nursing station.

3. On 6/7/17 at 1:00 PM, an interview was conducted with (E #3). E #3 stated that plastic bags are contraband and not permitted on the unit due to suffocation risk [for suicidal patients].

C. Based on document review and interview, it was determined, for 1 of 10 clinical records reviewed (Pt. #7), the Hospital failed to ensure a patient on suicide precautions was monitored every 15 minutes, as required by policy.

Findings include:

1. On 6/7/17 at 11:00 AM, the Hospital policy titled, "Observation Levels", effective November 2014, was reviewed. The policy required, "... Special precaution procedures can be initiated by physician or nursing staff when a patient may be considered to be an increased risk for harm to self, others, or property... A Patient Round Sheet reflects the patient's location and observed behaviors, [and is] completed every 15 minutes..."

2. On 6/7/17 at 9:45 AM, Pt. #7's clinical record was reviewed. Pt. #7 was a 17 year old female, admitted on 6/4/17, with a diagnosis of major depressive disorder. Pt. #7's admission orders dated 6/4/17 at 11:50 PM, included suicidal precautions. Pt. #7's "Patient Safety Precautions Record" dated 6/6/17, included 15 minutes close observation for suicide. However, 15 minute checks were missing on 6/7/17 between 10:15 PM and 11:15 PM, for 1 hour.

A 144 (C) 10/26/2017

All RN Staff were re-educated by June 22, 2017 to provide oversight for completion of 15 minute rounds sheets. 15 minute check documentation was revised, adding a field for documenting that RN Staff will perform at minimum one 15 minute checks per shift. As well, RN Staff will review documentation for completion, and confirm the completion of the form each shift.

Audits will be performed on 50 medical records monthly to ensure full and accurate completion of 15 minute rounds sheets.

The results will be reported to the Performance Improvement Committee. This will be monitored for four consecutive months with a measurement of success goal of 100% compliance.

Administration will do periodic random compliance reviews to ensure compliance with patient rounding. These reviews will occur weekly on all active patient care areas for four consecutive months. The person ultimately responsible for this action is the Chief Nursing Officer.

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A 144	Continued From page 5 3. On 6/7/17 at 11:20 AM, an in interview was conducted with a Registered Nurse (E #4). E #4 stated that she did not know why Pt. #7's safety check sheet was not completed, but it should have been completed.	A 144		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: A. Based on document review and interview, it was determined, for 2 of 5 clinical records reviewed (Pts. #3 & #5) for patients in restraint, seclusion, or physical hold, the Hospital failed to ensure a physician's order was written for a patient placed in restraint/seclusion. Findings include: 1. On 6/7/17 at 11:25 AM, the Hospital policy titled, "Restraint and/or Seclusion", effective 11/2014, was reviewed. The policy included, "II. Definitions... A. Restraints... 3. Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving... B. Non Restraints... 3. Time out is a restriction of a patient... to a designated area from which the patient is not physically prevented from leaving... Patient must voluntarily accept the time out... Time out is not to last more than 30 minutes."	A 168	A 168 (A) 6/26/2017 Restraint and Seclusion Order Form was revised, approved, and re-educated to all RN staff by June 22, 2017. Physicians were informed about changes in documentation. The updated Order Form required that each separate intervention, even if part of one event, required its own order form. All RN staff were educated on the hospital policy defining seclusion as "Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior", from policy "Restraint and/or Seclusion". Hospital Leadership developed a post-event review process to evaluate all uses of restraint and seclusion. This review process includes documentation evaluation, chart review, and staff education when needed. Results of the reviews are presented to the Performance Improvement Committee. The person ultimately responsible for the action is the Chief Nursing Officer.	

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2. On 6/7/17 at 1:25 PM, Pt. #3's clinical record was reviewed. Pt. #3 was a 43 year old male, admitted on 3/17/17, with a diagnosis of schizophrenia. Pt. #3's "Restraint/Seclusion Order Sheet" dated 3/19/17 at 10:10 PM, included a "manual hold", because "patient attacked staff". However, a "RN Progress Note" dated 3/20/17 at 3:05 AM, included, that on 3/19/17 "...At 9:45 PM, Patient lunged at and made physical contact with Mental Health Technician. Patient placed on manual hold... Patient escorted to seclusion room... Patient remained in seclusion room with door open, being monitored by staff until 10:05 PM. Patient offered water and snacks..." Pt. #3 returned to his room, but "after 30 minutes patient remains confused. Placed in quiet room for the remainder of the shift..."

3. On 6/7/17 at 2:20 PM, an in interview was conducted with the Director of Performance Improvement and Risk (E #3) and the Director of Nursing (E #6). E #6 stated that Pt. #3 was not in seclusion because the seclusion room door was left open and the Nurse documented the incident incorrectly.

4. The clinical record of Pt #5 was reviewed on 6/7/17 at approximately 1:50 PM. Pt #5 was a 16 year old female admitted on 4/15/17 with a diagnosis of disruptive mood dysregulation disorder. Pt #5's clinical record contained a Restraint/Seclusion Order Sheet dated 4/21/17 that included a physician's order for manual hold and 4 point mechanical restraints. Documentation indicated that Pt #5 was placed in a manual hold on 4/21/17 from 3:55 PM to 4:12 PM and then 4 point leather restraints from 4:31

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A 168	Continued From page 7 PM to 5:30 PM (19 minutes later). The clinical record lacked a second physician order for the placement of the mechanical restraints following the manual hold. 5. Pt #5's clinical record contained a Restraint/Seclusion Order Form dated 5/1/17 that required 4 point mechanical restraints. The order form indicated that Pt #5 was placed into a manual hold prior to the mechanical restraints without a physician's order. 6. An interview was conducted with the Director of Performance Improvement and Risk (E #3) and the Director of Nursing (E #6) on 6/7/17 at approximately 2:20 PM. E #3 and E #6 stated that there should have been a second order for the restraints because of the time lapse and there was no order for the patient to be placed in a manual hold.	A 168		
A 169	482.13(e)(6) PATIENT RIGHTS: RESTRAINT OR SECLUSION Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN). This STANDARD is not met as evidenced by: Based on document review and interview, it was determined that for 3 of 5 clinical records (Pts #2, 4, and 5) reviewed of patients in restraint, the Hospital failed to ensure that restraint orders did not include a PRN (as needed) component. Findings include: 1. The Hospital policy entitled, "Restraint and/or Seclusion," (Effective date:11/14) reviewed on	A 169		

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6/6/17 at approximately 11:00 AM required, "Policy...G. No PRN or standing orders for restraint or seclusion are permitted."

2. The clinical record of Pt #2 was reviewed on 6/7/17 at approximately 1:40 PM. Pt #2 was a 14 year old female admitted on 4/5/17 with a diagnosis of major depressive disorder. Pt #2's clinical record contained Restraint/Seclusion Order Sheets dated 4/17/17, 4/18/17 at 2:26 PM and 2:50 AM, and 4/19/17 that required "Manual Hold". The orders further included a signed physician's statement that indicated, "If needed for emergency management, restraint/seclude for..."

3. The clinical record of Pt #4 was reviewed on 6/7/17 at approximately 1:45 PM. Pt #4 was a 28 year old female admitted on 3/21/17 with a diagnosis of schizoaffective disorder. Pt #4's clinical record contained Restraint/Seclusion Order Sheets dated 4/6/17 and 4/30/17 that required "Manual Hold". The orders further included a signed physician's statement that indicated, "If needed for emergency management, restraint/seclude for..."

4. The clinical record of Pt #5 was reviewed on 6/7/17 at approximately 1:50 PM. Pt #5 was a 16 year old female admitted on 4/15/17 with a diagnosis of disruptive mood dysregulation disorder. Pt #5's clinical record contained Restraint/Seclusion Order Sheets dated 4/21/17, 4/26/17, and 4/29/17 that required "Manual Hold". The orders further included a signed physician's statement that indicated, "If needed for emergency management, restraint/seclude for..."

5. The Director of Nursing (E #6) stated, during

Restraint and Seclusion Order Form was revised, approved, and re-educated to all RN staff by June 22, 2017. Physicians were informed about changes in documentation. The updated Order Form required that each separate intervention, even if part of one event, required its own order form. The wording on the document was revised to remove the statement "If needed for emergency management, restraint/seclude for...".
Re-education was provided to all RN staff by June 22, 2017 on the hospital policy prohibiting the use of Restraint/Seclusion orders as PRN, from policy "Restraint and/or Seclusion".
Hospital Leadership developed a post-event review process to evaluate all uses of restraint and seclusion. This review process includes documentation evaluation, chart review, and staff education when needed. Results of the reviews are presented to the Performance Improvement Committee. The person ultimately responsible for the action is the Chief Nursing Officer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	144040	A. BUILDING _____ B. WING _____	C 06/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGO BEHAVIORAL HOSPITAL	555 WILSON LANE DES PLAINES, IL 60016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 169	Continued From page 9 an interview on 6/7/17 at approximately 2:30 PM, that the order did indicate that restraint/seclusion could be used as PRN.	A 169		
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours: (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: Based on document review and interview, it was determined that for 3 of 5 (Pts #2, 4, and 6) clinical records reviewed of patients with restraint usage, the Hospital failed to ensure patients were not restrained longer than allowed. Findings include: 1. The Hospital policy entitled, "Restraint and/or Seclusion," (effective date:11/14) reviewed on 6/6/17 at approximately 11:00 AM required, "Policy...J. restraints/seclusions orders...4 hours for adults (18 years and older), 2 hours for children and adolescents age 9 - 17.. Procedures...12. Completes required documentation regarding patients in restraint including..."	A 171	A171 Restraint and Seclusion Order Form was revised, approved, and re-educated to all RN staff by June 22, 2017. Physicians were informed about changes in documentation. The updated Order Form required that each separate intervention, even if part of one event, required its own order form. The order form states the maximum time interventions can be applied, per state law, based off of age of the patient. RN Supervisors were re-educated by June 30, 2017 to provide oversight to ensure that times are accurately documented, and that interventions do not exceed maximum times per state law. Hospital Leadership developed a post-event review process to evaluate all uses of restraint and seclusion. This review process includes documentation evaluation, chart review, and staff education when needed. Results of the reviews are presented to the Performance Improvement Committee. The person ultimately responsible for the action is the Chief Nursing Officer.	6/30/2017

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A 171	Continued From page 10 2. The clinical record of Pt #2 was reviewed on 7/7/17 at approximately 1:40 PM. Pt #2 was a 14 year old female admitted on 4/5/17 with a diagnosis of major depressive disorder. Pt #2's clinical record contained Restraint/Seclusion Order Sheets dated 4/19/17 and 4/20/17 at 9:00 AM and at 4:25 PM that indicated Pt #2 had been placed into 4 point mechanical restraints. The order forms lacked either the time Pt #2 was placed into restraints and/or removed, to assure Pt #2 was not restrained longer than the policy allowed. 3. The clinical record of Pt #4 was reviewed on 6/7/17 at approximately 1:45 PM. Pt #4 was a 28 year old female admitted on 3/21/17 with a diagnosis of schizoaffective disorder. Pt #4's clinical record contained Restraint/Seclusion Order Sheets dated 3/22/17 at 7:30 AM, 10:45 AM, and 4:30 PM and 3/25/17. The orders failed to include the maximum hours allowed, as required by the order form. 4. The Director of Nursing (E #6) stated, during an interview on 6/7/17 at approximately 2:30 PM, that the documentation did not indicate the time of restraint usage.	A 171		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on document review and interview, it was determined that for 1 of 1 (Pt #1) clinical record reviewed for ordering of medications, the Hospital failed to ensure medications were	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 395	Continued From page 11 obtained and administered as ordered. Findings include: 1. The Hospital policy entitled, "Written Medication Orders," (reviewed December 2015) reviewed on 6/7/17 at approximately 1:15 PM required, "...B. Nursing...2. Nursing forwards the written order copy to the pharmacy in a timely manner." 2. The Hospital policy entitled, "After Hours Procurement of Medications," (reviewed December 2015) reviewed on 6/7/17 at approximately 1:20 PM required, "I. Policy: The pharmacy shall maintain a limited supply of commonly used drugs in a specially designated location for urgent/emergent use." 3. The clinical record of Pt #1 was reviewed on 6/6/17 at approximately 10:15 AM. Pt #1 was a 14 year old female admitted on 4/19/17 with diagnoses that included, major depression and suicide ideation. Pt #1's clinical record included physician's admitting orders dated 4/19/17 at 11:00 PM that included, Pt #1's home medication record that included: home medications - Zoloft (anti-depressant) and Melatonin (hormone used for sleep) and the last time taken was 4/18/17. Documentation included that the physician's order was faxed to the pharmacy on 4/21/17. Pt #1's clinical record included a Medication Administration Record with the initial date of 4/21/17. The record indicated that Pt #1's Zoloft (Sertraline) 125 mg was started on 4/20/17; however, the first documented dose was on 4/21/17. Pt #1's Melatonin 5 mg was started on 4/21/17.	A 395	A395 Policy entitled "Physician Orders" was amended to reflect that medication orders are hand delivered or faxed to the pharmacy. RN Staff was re-educated by June 22, 2017 by the Chief Nursing Officer to clarify the policy. The person ultimately responsible for this action is the Director of Pharmacy. A395 The Director of Pharmacy/Designee is available 24 hours daily, to ensure that all medications ordered have been dispensed per physician's order, in a timely manner. Pharmacy Director/Designee ensures that medications are stocked and available during off hours, per policy. Ongoing compliance is being monitored via weekly pharmacy, storage, and medication room inspections. Ongoing audits are completed to ensure all medications ordered were received by the pharmacy within four hours of transcription. RN Staff were re-educated by June 22, 2017 about the process for obtaining medications on off hours. This includes use of the night cabinet, obtaining medications from a local pharmacy, or contacting the Director of Pharmacy/Designee for guidance. This audit will be reported to the Pharmaceuticals and Therapeutics Committee, and the Performance Improvement Committee. The person ultimately responsible for this action is the Director of Pharmacy.	6/26/2017 6/26/2017

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A 395	Continued From page 12	A 395		

4. MD #1 stated during the interview on 6/6/17 at approximately 1:00 PM, "When a patient is admitted, the way medications are ordered is through the med reconciliation. I check continue home meds or discontinue the meds. I continued the home meds of the patient (Pt #1)."

5. A registered nurse (E #4) stated during the interview on 6/7/17, "When a patient is admitted and we get orders from the doctor, the home medications are reviewed and the physician decides which ones to keep. The order is then sent to the pharmacy."

6. On 6/7/17 at approximately 12:15 PM, the Pharmacist (E #5) was interviewed. E #5 stated, "When a patient is admitted at night and is in need of medications, there is a night cabinet available for use. In the morning, we would get the form and the order from the cabinet and fill the order. Looking at my computer, I see the first medication that was sent from the pharmacy was on 4/21/17. There is no documentation in the night cabinet book to indicate the patient received a dose upon admission. The order for the medication is dated 4/19/17 at 11:00 PM and signed by the doctor on 4/20/17 at 10:00 AM but was not faxed to us until 4/21/17."